


PTSD at School

Stephen E. Brock, Ph.D., NCSP
California State University, Sacramento
brock@csus.edu

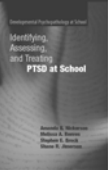


Idaho School Counselor Association (ISCA) & Idaho School Psychologist Association (ISPA) Critical Skills and Issues in School Psychology Fall Conference, October 2, 2008, Boise, ID

1

Acknowledgements

- Adapted from...
Nickerson, A. B., Reeves, M. A., Brock, S. E., & Jimerson, S. R. (in press). *Assessing, identifying, and treating posttraumatic stress disorder at school*. New York: Springer.



2

Preface

- Trauma is a..
 - “blow to the psyche that breaks through one’s defenses so suddenly and with such force that one cannot respond effectively.”

Kai Erickson
In the Wake of a Flood, 1979

3

Preface

- PTSD necessarily involves exposure to a traumatic stressor.
- A traumatic stressor can generate initial stress reactions in just about anyone.
- However, not everyone exposed to these events develops PTSD.
 - Typically, the majority of exposed individuals recover and only a minority develop PTSD.
- Among those who develop PTSD, significant impairments in daily functioning (including interpersonal and academic functioning) are observed.
- Developmentally younger individuals are more vulnerable to PTSD.

4

Preface

- Prevalence among children and adolescents
 - General Population
 - Trauma Exposure approximately 25%
 - PTSD 6 to 10%
 - Urban Populations
 - Trauma Exposure as high as 80%
 - PTSD as high as 30%

Buka et al., 2001; Costello et al., 2002; Dyregory & Yule, 2006; Seedat et al., 2004⁵

Preface

Range of Possible Traumatic Stress Reactions

Not Psychopathological (Common)

↑

Initial Crisis Reactions
Acute Stress Disorder
Acute Post-Traumatic Stress Disorder
Chronic Post-Traumatic Stress Disorder

↓

Psychopathological (Uncommon)

6

Preface

- PTSD among children
 - Frequency
 - Similarities with adult PTSD
 - Differences from adult PTSD

7

Preface

- The role of the school-based mental health professional **is** to be ...
 - able to recognize and screen for PTSD symptoms.
 - aware of the fact PTSD may generate significant school functioning challenges.
 - knowledgeable of effective treatments for PTSD and appropriate local referrals.
 - cognizant of the limits of their training.
- It **is not** necessarily to ...
 - diagnose PTSD.
 - treat PTSD.

8

Workshop Outline

- DSM-TR-IV Diagnostic Criteria
- Causes
- Consequences
 - Cognitive
 - Emotional and Behavioral
 - Academic
- Initial Assessment (or Screening)
- Interventions
 - Prevention
 - Academic
 - Psychological
 - Medical

9

DSM-IV-TR Diagnostic Criteria for PTSD

- An anxiety disorder that develops secondary to exposure (experiencing, witnessing, or learning about) to an “extreme traumatic stressor.”
 - An event that involves actual or threatened death or serious injury, or threat to ones physical integrity.
- “The person’s response to the event must involve intense fear, helplessness, or horror (or in children, the response must involve disorganized or agitated behavior).”

(APA, 2000, p. 463) 10

DSM-IV-TR Diagnostic Criteria for PTSD

- Traumatic events **directly experienced** may include, but are not limited to
 - Military combat
 - Violent personal assault
 - Being kidnapped
 - Being taken hostage
 - Terrorist attack
 - Torture
 - Natural or manmade disasters
 - Severe automobile accidents
 - Being diagnosed with a life-threatening illness
- Among children these events may include
 - Developmentally inappropriate sexual experiences

11

DSM-IV-TR Diagnostic Criteria for PTSD

- Traumatic events that are **witnessed** may include, but are not limited to
 - Observing the serious injury/death of another person due to
 - Violent assault
 - Accident
 - War
 - Disasters
 - Unexpectedly witnessing a dead body or body parts.

12

DSM-IV-TR Diagnostic Criteria for PTSD

- Traumatic events that are experienced by others and that are subsequently **learned about** may include, but are not limited to
 - Violent personal assault
 - Serious accident
 - Serious injury experienced by a significant other
 - Learning about sudden unexpected death of a significant other

13

DSM-IV-TR Diagnostic Criteria for PTSD

- Core Symptoms
 1. Persistent reexperiencing of the trauma.
 2. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness.
 3. Persistent symptoms of increased arousal.
- Duration of the disturbance is more than one month.
- The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

APA, 2000 14

DSM-IV-TR Diagnostic Criteria for PTSD

- Reexperiencing Symptoms
 1. Recurrent/intrusive distressing recollections.
 2. Recurrent distressing dreams.
 3. Acting/feeling as if the event were recurring.
 4. Psychological distress at exposure to cues that symbolize/resemble the traumatic event.
 5. Physiological reactivity on exposure to cues that symbolize/resemble the traumatic event.

APA, 2000 15

DSM-IV-TR Diagnostic Criteria for PTSD

- Avoidance & Numbing Symptoms
 1. Avoids thoughts, feelings, or conversations.
 2. Avoids activities, places, or people.
 3. Inability to recall important aspects of the trauma.
 4. Diminished interest/participation in significant activities.
 5. Feeling of detachment/estrangement.
 6. Restricted range of affect.
 7. Sense of a foreshortened future.

APA, 2000 16

DSM-IV-TR Diagnostic Criteria for PTSD

- Increased Arousal Symptoms
 1. Difficulty falling or staying asleep.
 2. Irritability or outbursts of anger.
 3. Difficulty concentrating.
 4. Hypervigilance.
 5. Exaggerated startle response.

APA, 2000 17

DSM-IV-TR Diagnostic Criteria for PTSD

- PTSD may be specified as
 - Acute
 - Chronic
 - Delayed onset

APA, 2000 18

DSM-IV-TR Diagnostic Criteria for PTSD

- Associated Features
 - Survivor guilt
 - Impaired social/interpersonal functioning
 - Auditory hallucinations & paranoid ideation
 - Impaired affect modulations
 - Self-destructive and impulsive behavior
 - Somatic complaints
 - Shame, despair, or hopelessness
 - Hostility
 - Social withdrawal

APA, 2000 19

DSM-IV-TR Diagnostic Criteria for PTSD

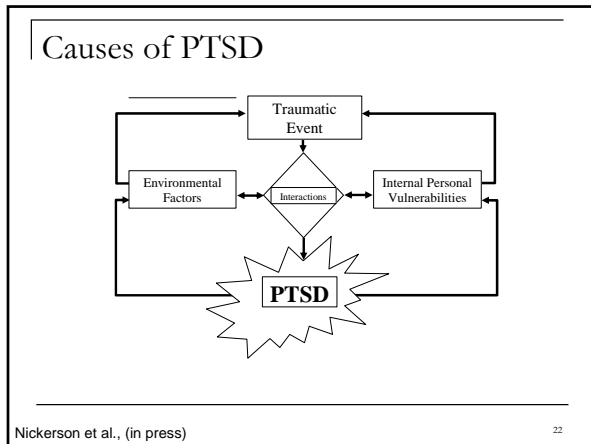
- Associated Mental Disorders
 - Major Depressive Disorder
 - Substance-Related Disorders
 - Panic Disorder
 - Agoraphobia
 - Obsessive-Compulsive Disorder
 - Generalized Anxiety Disorder
 - Social Phobia
 - Specific Phobia
 - Bipolar Disorder

APA, 2000 20

Workshop Outline

- DSM-TR-IV Diagnostic Criteria
- Causes
- Consequences
 - Cognitive
 - Emotional and Behavioral
 - Academic
- Initial Assessment (or Screening)
- Interventions
 - Prevention
 - Academic
 - Psychological
 - Medical

21



- ### Causes of PTSD
- **Traumatic Event Variables**
 - **Type**
 - Predictability
 - Assaultive Interpersonal Violence
 - Fatalities
 - **Severity**
 - Duration
 - Intensity
 - **Exposure**
 - Physical Proximity
 - Emotional Proximity
- Nickerson et al., (in press); Brock et al., (in preparation) 23

- ### Causes of PTSD
- **Environmental Factors**
 - Parental Reactions
 - Social Supports
 - History of Environmental Adversity/Traumatic Stress
 - Family Atmosphere
 - Family Mental Health History
 - Poverty
- Nickerson et al., (in press) 24

Causes of PTSD

- Internal Personal Vulnerabilities
 - Psychological Factors
 - Crisis Perceptions and Reactions
 - Mental Illness
 - Developmental Level
 - Coping Strategies
 - Locus of Control
 - Self-esteem

Nickerson et al., (in press) 25


Causes of PTSD

- Internal Personal Vulnerabilities (cont.)
 - Genetic Factors
 - Family Studies
 - Twin Studies
 - Candidate Gene Studies

Nickerson et al., (in press) 26

Causes of PTSD

- Internal Personal Vulnerabilities (cont.)
 - Neurobiological Factors



The diagram shows a sagittal cross-section of the human brain. Four specific regions are highlighted with boxes and labeled: the Hypothalamus and Pituitary gland are located in the lower anterior region; the Hippocampus is situated in the medial temporal lobe; and the Amygdala is located in the anterior temporal lobe, anterior to the hippocampus.

Nickerson et al., (in press) 27

Workshop Outline

- DSM-TR-IV Diagnostic Criteria
- Causes
- Consequences
 - Cognitive
 - Emotional and Behavioral
 - Academic
- Initial Assessment (or Screening)
- Interventions
 - Prevention
 - Academic
 - Psychological
 - Medical

28

Consequences of PTSD

- Cognitive (Eckenrodel et al., 1993)
 1. Motivation and persistence in academic tasks (Craig, 1992)
 2. Development of short- and long-term goals (Craig, 1992)
 3. Sequential memory (Craig, 1992)
 4. Ordinal positioning (Craig, 1992)
 5. Procedural memory
 6. Attention and Focus (Craig, 1992; Traweek, 2006)

29

Consequences of PTSD

- Emotional and behavioral
 1. Regression to childish/dependent behavior
 2. Fears/anxieties
 3. Changes in eating patterns
 4. Changes in sleeping patterns
 5. Gender differences
 6. School problems
 7. Disciplinary Referrals (Eckenrode et al., 1993)
 8. Freezing
 9. Dissociation
 10. Social functioning (Rucklidge, 2006)

30

Consequences of PTSD

- Academic (Eckenrodel et al., 1993)
 1. Academic achievement
 2. Academic performance (Kruczek, 2006; Gahen, 2005)
 3. Grade retention
 4. Adult outcome
 5. School behavior
 - Outbursts of anger, hyperactivity, impulsivity (Glod & Teicher, 1996)

31

Consequences of PTSD

- Co-morbid conditions
 - AD/HD
 - Depression
 - Obsessive/Compulsive Disorder
 - Oppositional/Defiant Disorder
 - Anxiety Disorder
 - Conduct Disorder

32

Consequences of PTSD

- Developmental considerations: **Preschoolers**
 - Reactions not as clearly connected to the crisis event as observed among older students.
 - Reactions tend to be expressed nonverbally.
 - Given equal levels of distress and impairment, may not display as many PTSD symptoms as older children.
 - Temporary loss of recently achieved developmental milestones.
 - Trauma related play.

American Psychiatric Association, 2000; Berkowitz, 2003; Cook-Cottone, 2004; Dulmus, 2003; Joshi & Lewjg, 2004; National Institute of Mental Health, 2001; Yorlrik et al., 2004.)

Consequences of PTSD

- Developmental considerations: **School-age children**
 - Reactions tend to be more directly connected to crisis event.
 - Event specific fears may be displayed.
 - Reactions are often expressed behaviorally.
 - Feelings associated with the traumatic stress are often expressed via physical symptoms.
 - Trauma related play (becomes more complex and elaborate).
 - Repetitive verbal descriptions of the event.
 - Problems paying attention.

American Psychiatric Association, 2000; Berkowitz, 2003; Cook-Cottone, 2004; Dulmus, 2003; Joshi & Lewjg, 2004; National Institute of Mental Health, 2001; Yorlrik et al., 2004)

Consequences of PTSD

- Developmental considerations: **Preadolescents and adolescents**
 - More adult like reactions
 - Sense of foreshortened future
 - Oppositional/aggressive behaviors to regain a sense of control
 - School avoidance
 - Self-injurious behavior and thinking
 - Revenge fantasies
 - Substance abuse
 - Learning problems

American Psychiatric Association, 2000; Berkowitz, 2003; Cook-Cottone, 2004; Dulmus, 2003; Joshi & Lewjg, 2004; National Institute of Mental Health, 2001; Yorlrik et al., 2004)

Workshop Outline

- DSM-TR-IV Diagnostic Criteria
- Causes
- Consequences
 - Cognitive
 - Emotional and Behavioral
 - Academic
- Initial Assessment (or Screening)
- Interventions
 - Prevention
 - Academic
 - Psychological
 - Medical

36

Initial Assessment of PTSD

Crisis Event Type*

- a) Human Caused (vs. Natural)
- b) Intentional (vs. Accidental)
- c) Fatalities

*Risk factors that increase the probability of psychological trauma and, as such, should result in increased vigilance for psychological trauma warning signs.

Brock (2006); Brock et al. (in preparation) 37

Initial Assessment of PTSD

Crisis Exposure*

- a) Physical proximity
 - Intensity of crisis experience
- b) Emotional proximity

*Risk factors that increase the probability of psychological trauma and, as such, should result in increased vigilance for psychological trauma warning signs.

Brock (2006); Brock et al. (in preparation) 38


Initial Assessment of PTSD

Physical Proximity

- Where were students when the crisis occurred (i.e., how close were they to the traumatic event)?
 - The closer they were (i.e., the more direct their exposure) the greater the risk of psychological trauma.
 - The more physically distant they were, the lower the risk of psychological trauma.

Brock (2006); Brock et al. (in preparation) 39

Initial Assessment of PTSD



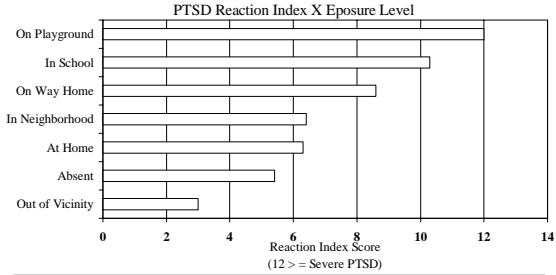
Physical Proximity

- Residents between 110th St. and Canal St.
 - 6.8% report PTSD symptoms.
- Residents south of Canal St (ground zero)
 - **20% report PTSD symptoms.**
- Those who did not witness the event
 - 5.5% had PTSD symptoms.
- Those who witnessed the event
 - **10.4% had PTSD symptoms.**

Galea et al. (2002) 40

Initial Assessment of PTSD

Physical Proximity
PTSD Reaction Index X Exposure Level

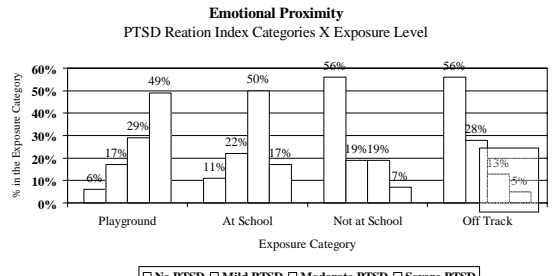


Exposure Level	Reaction Index Score (12 > = Severe PTSD)
On Playground	12
In School	10
On Way Home	8
In Neighborhood	6
At Home	6
Absent	5
Out of Vicinity	3

Pynoos et al. (1987) 41

Initial Assessment of PTSD

Emotional Proximity
PTSD Reaction Index Categories X Exposure Level



Exposure Category	No PTSD	Mild PTSD	Moderate PTSD	Severe PTSD
Playground	6%	17%	29%	49%
At School	11%	22%	17%	50%
Not at School	19%	19%	7%	56%
Off Track	13%	15%	28%	56%

Source: Pynoos et al. (1987) 42

Initial Assessment of PTSD

Emotional Proximity

- Individuals who have/had close relationships with crisis victims should be made crisis intervention treatment priorities.
- May include having a friend who knew someone killed or injured.

Brock (2006); Brock et al. (in preparation) 43

Initial Assessment of PTSD

Emotional Proximity
PTSD and Relationship to Victim X Outcome
(i.e., injury or death)

Outcome Category	Parent/Sibling	Other Family	Friend	Other Person	No one
Person Injured	22%	15%	15%	12%	8%
Person Died	52%	25%	18%	11%	9%

Applied Research and Consulting et al. (2002, p. 34) 44

Initial Assessment of PTSD

Personal Vulnerabilities*

- Internal vulnerability factors
- External vulnerability factors

*Risk factors that increase the probability of psychological trauma and, as such, should result in increased vigilance for psychological trauma warning signs.

Brock (2006); Brock et al. (in preparation) 45

Initial Assessment of PTSD

Internal Vulnerability Factors

- Avoidance coping style
- Pre-existing mental illness
- Poor self regulation of emotion
- Low developmental level and poor problem solving
- History of prior psychological trauma
- Self-efficacy and external locus of control

Brock (2006); Brock et al. (in preparation) 46

Initial Assessment of PTSD

External Vulnerability Factors

- Family resources
 - Not living with nuclear family
 - Ineffective & uncaring parenting
 - Family dysfunction (e.g., alcoholism, violence, child maltreatment, mental illness)
 - Parental PTSD/maladaptive coping with the stressor
 - Poverty/financial Stress
- Social resources
 - Social isolation
 - Lack of perceived social support

Brock (2006); Brock et al. (in preparation) 47

Initial Assessment of PTSD

Threat Perceptions*

- Subjective impressions can be more important that actual crisis exposure.
- Adult reactions are important influences on student threat perceptions.

* Risk factor that increase the probability of psychological trauma and, as such, should result in increased vigilance for psychological trauma warning signs.

Brock (2006); Brock et al. (in preparation) 48

Initial Assessment of PTSD

Crisis Reactions*

Severe acute stress reactions predict PTSD.
Reactions suggesting the need for an immediate mental health referral

- Dissociation
- Hyperarousal
- Persistent re-experiencing of the crisis event
- Persistent avoidance of crisis reminders
- Significant depression
- Psychotic symptoms


*Warning signs that provide concrete indication of psychological trauma

Brock (2006); Brock et al. (in preparation) 49

Initial Assessment of PTSD

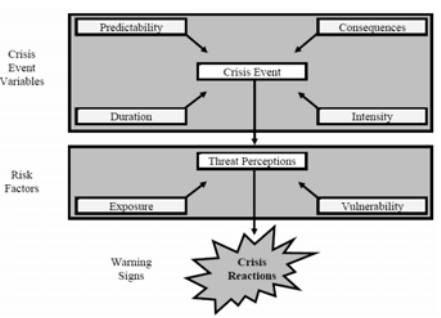
Crisis Reactions

- Cultural considerations
 - Other important determinants of crisis reactions in general, and grief in particular, are family, cultural and religious beliefs.
 - Providers of crisis intervention assistance should inform themselves about cultural norms with the assistance of community cultural leaders who best understand local customs.



Lipson, J. G., & Dibble, S. L. (Eds.). (2005). *Culture & clinical care*. San Francisco: UCSF Nursing Press.

Initial Assessment of PTSD



The diagram illustrates the process of crisis reactions. It is divided into two main sections: Crisis Event Variables and Risk Factors. Crisis Event Variables include Predictability, Consequences, Duration, and Intensity, all of which point to a central box labeled 'Crisis Event'. Risk Factors include Exposure and Vulnerability, which point to a box labeled 'Threat Perceptions'. Both 'Crisis Event' and 'Threat Perceptions' have arrows pointing down to a starburst shape labeled 'Crisis Reactions'. A 'Warning Signs' label is positioned to the left of the 'Crisis Reactions' starburst.

Brock et al. (in preparation) 51

Initial Assessment of PTSD

Multi-Method & Multi-Source

- "Traumatized youths do not generally seek professional assistance, and recruiting school personnel to refer trauma-exposed students to school counselors can also leave many of these students unidentified."
- "These findings suggest that a more comprehensive assessment of exposure parameters, associated distress, and impairment in functioning is needed to make informed treatment decisions, especially given the possibility of inaccuracies in child and adolescent reports of the degree of exposure and the great variability in responses to similar traumatic events observed among survivors."

Saltzman et al. (2001, p. 292) 52

Initial Assessment of PTSD

Primary Evaluation of Psychological Trauma

- Takes place immediately after the crisis
- Initial Risk Screening Form

Brock (2006); Brock et al. (in preparation) 53

Initial Assessment of PTSD

Secondary Evaluation of Psychological Trauma

- Begins as soon as school crisis interventions begin to be provided.
- Designed to identify those who are actually demonstrating warning signs of psychological trauma and to make more informed school crisis intervention treatment decisions.

Brock (2006); Brock et al. (in preparation) 54

Initial Assessment of PTSD

Secondary Evaluation of Psychological Trauma

- Typically includes assessment of the following risk factors and warning signs
 - Crisis exposure (physical and emotional proximity)
 - Personal vulnerabilities
 - Crisis reactions
 - Typically involves the following strategies
 - Use of parent, teacher, peer, and self-referral procedures/forms
 - Administering individual and/or group screening measures

Brock (2006); Brock et al. (in preparation) 55

Initial Assessment of PTSD

Secondary Evaluation of Psychological Trauma

- Parent, teacher, and self-referral procedures/forms
 - Elements of a referral form
 - Identifying information
 - Physical proximity
 - Emotional proximity
 - Vulnerabilities
 - Personal history
 - Resources
 - Mental health

Brock (2006); Brock et al. (in preparation) 56

Initial Assessment of PTSD

Secondary Evaluation of Psychological Trauma

- Elements of a referral form (continued)
 - Crisis Reactions
 - Dissociation
 - Hyperarousal
 - Re-experiencing
 - Avoidance
 - Depression
 - Psychosis
 - Dangerous coping efforts (i.e., behaviors that involve any degree of lethality)

Source: Brock (2006) 57

Initial Assessment of PTSD

Secondary Evaluation of Psychological Trauma

Measure	Author	Age Group	Admin Time	Availability
Trauma Symptom Checklist for Children	Briere (1996)	7-16 yrs.	20 min.	www3.parinc.com
Children's PTSD Symptom Scale	Foa (2002) Foa et al. (2001)	8-15 yrs.	10 min.	foa@mail.med.upenn.edu
Parent Report of Posttraumatic Symptoms	Greenwald & Rubin (1999)	Grd. 4-8	5 min.	www.childtrauma.com/ax.html#n
Child Report of Posttraumatic Symptoms	Greenwald & Rubin (1999)	Grd. 4-8	5 min.	www.childtrauma.com/ax.html#n

58

Initial Assessment of PTSD

Secondary Evaluation of Psychological Trauma

Measure	Author	Age Group	Admin Time	Availability
Child's Reactions to Traumatic Events Scale	Jones et al. (2002)	8-12 yrs.	5 min.	rtjones@vt.edu
UCLA PTSD Reaction Index for DSM-IV (Child, Adolescent, and Parent)	Pynoos et al. (1998) Steinberg et al. (n.d.)	7 yrs - adult	20 min.	Asteinberg@mednet.ucla.edu
Children's PTSD Inventory	Saigh (2004) Saigh et al. (2000)	6-18 yrs.	5-20 min.	www.HarcourtAssessment.com
Pediatric Emotional Distress Scale	Saylor (2002) Saylor et al. (1999)	2-10 yrs.	5-10 min.	www.mentalhealth.org/publications/allpubs/SMA95-3022/default.asp

59

Initial Assessment of PTSD

Tertiary Evaluation of Psychological Trauma

- Screening for psychiatric disturbances (e.g., PTSD) typically begins weeks after a crisis event has ended. It is designed to identify that minority of students and/or staff who will require mental health treatment referrals.
- Typically includes the careful monitoring of crisis reactions/student and staff adjustment as ongoing school crisis intervention assistance is provided.

Brock (2006) 60

Workshop Outline

- DSM-TR-IV Diagnostic Criteria
- Causes
- Consequences
 - Cognitive
 - Emotional and Behavioral
 - Academic
- Initial Assessment (or Screening)
- Interventions
 - Prevention
 - Academic
 - Psychological
 - Medical

61

Interventions for PTSD

- Prevention of PTSD
 - Foster Internal Resiliency
 - Promote active (or approach oriented) coping styles.
 - Promote student mental health.
 - Teach students how to better regulate their emotions.
 - Develop problem-solving skills.
 - Promote self-confidence and self-esteem.
 - Promote internal locus of control.
 - Validate the importance of faith and belief systems.
 - Others?

Brock (2006); Brock et al. (in preparation)

62

Interventions for PTSD

- Prevention of PTSD
 - Foster External Resiliency
 - Support families (i.e., provide parent education and appropriate social services).
 - Facilitate peer relationships.
 - Provide access to positive adult role models.
 - Ensure connections with pro-social institutions.
 - Others?

Brock (2006); Brock et al. (in preparation)

63

Interventions for PTSD

- **Prevention of PTSD**
 - **Keep Students Safe**
 - Remove students from dangerous or harmful situations.
 - Implement disaster/crisis response procedures (e.g., evacuations, lockdowns, etc.).
 - "The immediate response following a crisis is to ensure safety by removing children and families from continued threat of danger" (Joshi & Lewin, 2004, p. 715).
 - "To begin the healing process, discontinuation of existing stressors is of immediate importance" (Barenbaum et al., 2004, p. 48).

Brock (2006); Brock et al. (in preparation) 64

Interventions for PTSD

- **Prevention of PTSD**
 - **Avoid Crisis Scenes, Images, and Reactions of Others**
 - Direct ambulatory students away from the crisis site.
 - Do not allow students to view medical triage.
 - Restrict and/or monitor television viewing.
 - Minimize exposure to the traumatic stress reactions seen among others (especially adults who are in caregiving roles)

Brock (2006); Brock et al. (in preparation) 65

Interventions for PTSD

- **Academic Interventions**
 1. Use a constructivist approach
 2. Include discovery of competence
 3. Hunter's Lesson Plan Model
 4. Cooperative learning

66

Interventions for PTSD

- Academic Interventions: Executive Functioning
 - Promote Initiation/Focus
 1. Increase structure
 2. Consistent and predictable daily routines
 3. Short breaks and activities
 4. External prompting (cues, oral directions)
 5. Allow time for self-engagement instead of expecting immediate compliance

67

Interventions for PTSD

- Academic Interventions: Executive Functioning (cont.)
 - Holding = maintain information in working memory until can process and act upon
 1. Shorten multi-step directions
 2. Post the directions on board/in classroom
 3. Provide visual aides
 4. Use visualization or "seeing" the information as a teaching strategy

68

Interventions for PTSD

- Academic Interventions: Executive Functioning (cont.)
 - Inhibition = resistance to act upon first impulse
 1. Modeling, teaching, and practicing mental routines encouraging child to stop and think
 - Stop! Think. Good choice? Bad Choice?
 2. Anticipate when behavior is likely to be a problem
 3. Examining situations/environments to identify antecedent conditions that will trigger disinhibited behavior – alter those conditions
 4. Explicitly inform student of the limits of acceptable behavior
 5. Provide set routines with written guidelines

69

Interventions for PTSD

- Academic Interventions: Executive Functioning (cont.)
 - Monitoring = ability to check for accuracy
 1. Model, teach, and practice use of monitoring routines
 2. Prompt student if they fail to self-cue
 3. Provide opportunities for guided practice

70

Interventions for PTSD

- Psychological Interventions
 - General Therapy Issues
 - Clarifying the facts about the traumatic event
 - Normalizing reactions
 - Encouraging expression of feelings
 - Provide education to the child about experience
 - Encourage exploration and correction of inaccurate attributions regarding the trauma
 - Stress management strategies

71

Interventions for PTSD

- Psychological Interventions
 - Early Interventions
 - Cognitive Behavioral Therapies
 - Groups Approaches
 - Other Treatments

72

Interventions for PTSD

- Psychological Interventions
 - General Immediate Crisis Intervention Issues
 1. Cultural differences
 2. Body language
 3. Small groups
 4. Genders
 5. Appropriate tools
 6. Frequent breaks
 7. Develop narrative

73

Interventions for PTSD

- Psychological Interventions
 - Recommended Early Interventions
 - Minimize crisis exposure
 - Ensure that the child feels safe
 - Facilitate the cognitive mastery
 - Stimulate family communication and support

Dyregov & Yule (2006) 74

Interventions for PTSD

- Psychological Interventions
 - Questionable Early Interventions
 - Psychological Debriefing (e.g., Critical Incident Stress Debriefing)
 - No evidence to suggest it prevents PTSD
 - No evidence to suggest it increases adverse psychological reactions
 - May reduce trauma-related symptoms

Cohen (2003); Stallard & Slater (2003) 75

Interventions for PTSD

- Meta-analysis of single session debriefings.
- Utilized CISD interventions.
- Intervention provided within one month of event.
 - Results: CISD was not found to be effective in lowering the incidence of PTSD.

Van Emmerik et al. (2002) 76

Interventions for PTSD

- Conclusions about CISD and PTSD
 - May interfere natural processing of a traumatic event
 - May inadvertently lead victims to bypass natural supports (i.e., family and friends)
 - May increase awareness to normal reactions of distress and suggest that those reactions warrant professional care
 - Group debriefings were not effective in lowering the incidence of PTSD
 - In some cases, debriefing was suggested to be more harmful than good.
 - Appear to have made those who were acutely psychologically traumatized worse.

77

Interventions for PTSD

- Psychosocial Interventions
 - Empirically Supported Cognitive-Behavioral Approaches
 1. Exposure Therapy
 2. Cognitive Restructuring
 3. Stress Inoculation Training
 4. Anxiety Management Training
 5. Trauma Focused CBT

Dyregrov & Yule (2005), Feeny et al. (2004), NIMH (2007) 78

Interventions for PTSD

- Psychological Interventions
 - Empirically Supported Cognitive Behavioral Approaches
 - Exposure Therapy
 - Designed to help children confront feared objects, situations, memories, and images associated with the crisis event.
 - Face and gain control of overwhelming fear and distress.

Carr (2004), NIMH (2007) 79

Interventions for PTSD

- Psychological Interventions
 - Empirically Supported Cognitive Behavioral Approaches
 - Exposure Therapy
 - Imaginal Exposure
 - Repeated re-counting of (or imaginal exposure to) the traumatic memory; uses imagery or writing
 - In Vivo Exposure
 - Visiting the scene of the trauma

Carr (2004), NIMH (2007) 80

Interventions for PTSD

- Psychological Interventions
 - Empirically Supported Cognitive Behavioral Approaches
 - Exposure Therapy
 - Involves ...
 - Visualization
 - Anxiety rating
 - Habituation

Carr (2004), NIMH (2007) 81

Interventions for PTSD

- Psychological Interventions
 - Cognitive-Behavioral Approaches
 - "Overall, there is growing evidence that a variety of CBT programs are effective in treating youth with PTSD" ... "Practically, this suggests that psychologists treating children with PTSD can use cognitive-behavioral interventions and be on solid ground in using these approaches" (Feeny et al., 2004, p. 473).

82

Interventions for PTSD

- Psychological Interventions
 - Cognitive-Behavioral Approaches
 - "In sum, cognitive behavioral approaches to the treatment of PTSD, anxiety, depression, and other trauma-related symptoms have been quite efficacious with children exposed to various forms of trauma" (Brown & Bobrow, 2004, p. 216).

83

Interventions for PTSD

- Psychological Interventions
 - Group Approaches
 - Group-Delivered Cognitive-Behavioral Interventions
 - The effectiveness of group interventions has been proven effective among refugee children.
 - Benefits of a group approach included:
 - Assisted a large number of students at once.
 - Decreased sense of hopelessness.
 - Normalizes reactions.

Ehnholt et al. (2005) 84

Interventions for PTSD

- Psychological Interventions
 - Other Approaches
 - Eye Movement Desensitization and Reprocessing (EMDR)
 - Uses elements of cognitive behavioral and psychodynamic treatments
 - Employs an Eight-Phase treatment approach
 - Principals of dual stimulation set this treatment apart: tactile, sound, or eye movement components
 - Narrative Exposure Therapy

85

Interventions for PTSD

- EMDR Pros
 - More efficient (less total treatment time)
 - Reduces trauma related symptoms
 - Comparable to other Cognitive Behavioral Therapies
 - Suggested to be more effective than Prolonged Exposure

Korn et al. (2002) 86

Interventions for PTSD

- EMDR Cons
 - Limited research with children
 - No school-based research
 - Referral to a trained professional is required

Perkins et al. (2002) 87

Interventions for PTSD

- **Medical Treatments for PTSD**
 - Limited research
 - Imipramine
 - Without more and better studies documenting good effects and absence of serious side-effects, we urge clinicians to exercise extreme caution in using psycho-pharmacological agents for children, especially as CBT-methods are available to reduce posttraumatic symptoms and PTSD" (Dyregrov & Yule, 2006,p. 181)

References

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, D.C., Author.

Applied Research and Consulting, Columbia University Mailman School of Public Health, & New York Psychiatric Institute. (2002, May 6). *Effects of the World Trade Center attack on NYC public school students: Initial report to the New York City Board of Education*. New York: New York City Board of Education.

Barenbaum, J., Ruchkin, V., & Schwab-Stone, M. (2004). The psychosocial aspects of children exposed to war: Practice and policy initiatives. *Journal of Child Psychology and Psychiatry, 45*, 41-62.

Berkowitz, S. J. (2003). Children exposed to community violence: The rationale for early intervention. *Clinical Child and Family Psychology Review, 6*, 293-302

Brock, S. E. (2006, July). *Crisis intervention and recovery: The roles of school-based mental health professionals*. Bethesda, MD: National Association of School Psychologists.

Selected References

Brock, S. E. (2006). *Crisis intervention and recovery: The roles of school-based mental health professionals*. (Available from National Association of School Psychologists, 4340 East West Highway, Suite 402, Bethesda, MD 20814).

Brock, S. E., Nickerson, A. B., Reeves, M. A., Jimerson, S. R., Lieberman, R. A., & Feinberg, T. (in preparation). *School crisis prevention and intervention* Bethesda, MD: NASP.

Brown, E. J., & Bobrow, A. L. (2004). School entry after a community-wide trauma: Challenges and lessons learned from September 11th, 2001. *Clinical Child and Family Psychology Review, 7*, 211-221;

Buka, S. L., Stichick, T. L., Birdthistle, I., & Earls, F. J. (2001). Youth exposure to violence: Prevalence, risks, and consequences. *American Journal of Orthopsychiatry, 71*, 298-310.

Carr, A. (2004). Interventions for post-traumatic stress disorder in children and adolescents. *Pediatric Rehabilitation, 7*, 231-244.

Cook-Cottone, C. (2004). Childhood posttraumatic stress disorder: Diagnosis, treatment, and school reintegration. *School Psychology Review, 33*, 127-139.

Selected References

Costello, E. J., Erkanli, A., Fairbank, J. A., & Angold, A. (2002). The prevalence of potentially traumatic events in childhood and adolescence. *Journal of Traumatic Stress, 15*, 99-112.

Dulmus, C. N. (2003). Approaches to preventing the psychological impact of community violence exposure on children. *Crisis Intervention, 6*, 185-201.

Dyregrov, A., & Yule, W. (2006). A review of PTSD in children. *Child and Adolescent Mental Health, 11*, 176-184.

Ehnholt, A. K, Smith, A. P, & Yule, W. (2005). School-based cognitive-behavioural therapy group intervention for refugee children who have experienced war-related trauma. *Clinical Child Psychology and Psychiatry, 10*, 235-250.

Feeny, N. C., Foa, E. B., Treadwell, K. R. H., & March, J. (2004). Posttraumatic stress disorder in youth: A critical review of the cognitive and behavioral treatment outcome literature. *Professional Psychology: Research and Practice, 35*, 466-476.

91

Selected References

Gahen, S. A. (2005). The relationship between exposure to community violence, academic performance, behavioral functioning and protective factors in urban youth. *Dissertation Abstracts International Section A: Humanities and Social Sciences, 65(7-A)*, 2488.

Galea, S., Ahern J., Resnick, H., Kilpatrick, D., Bucuvalas, M., Gold, J., & Vlahov, D. (2002). Psychological sequelae of the September 11 terrorist attacks in New York City. *New England Journal of Medicine, 346*, 982-987.

Glod, C.A. & Teicher, M. (1996). Relationship between early abuse, posttraumatic stress disorder, and activity levels in prepubertal children. *Journal of American Academy of Child & Adolescent Psychiatry, 34*, 1384-1392.

Joshi, P. T., & Lewin, S. M. (2004). Disaster, terrorism and children. *Psychiatric Annals, 34*, 710-716

Korn, D., & Leeds, A. (2002). Preliminary evidence of efficacy for EMDR resource development and Installation in the stabilization phase of treatment of complex posttraumatic stress disorder. *Journal of Clinical Psychology, 58*, 1-22.

92

Selected References

Kruczek T. & Salsman J. (2006). Prevention and treatment of posttraumatic stress disorder in the school setting. *Psychology in the Schools, 43*, 461-470.

Lipson, J. G., & Dibble, S. L. (Eds.). (2005). *Culture & clinical care*. San Francisco: UCSF Nursing Press.

National Institute of Mental Health. (2001). *Mental health and mass violence: Evidence-based early psychological intervention for victims/survivors of mass violence. A workshop to reach consensus on best practices*. Washington, DC: U.S. Government Printing Office.

National Institute of Mental Health. (2007). *NIMH Fact Sheet: Post-Traumatic Stress Disorder Research*. Retrieved June 30, 2007, from <http://www.nimh.nih.gov/publicat/post-traumatic-stress-disorder-research-fact-sheet.cfm>

Nickerson, A. B., Reeves, M. A., Brock, S. E., & Jimerson, S. R. (in preparation). *Assessing, identifying, and treating posttraumatic stress disorder at school*. New York: Springer.

93

Selected References

Perkins, B., & Rouanzion, C. (2002). A critical evaluation of current views regarding eye movement desensitization and reprocessing (EMDR): Clarifying points of confusion. *Journal of Clinical Psychology, 58*, 77-97.

Pynoos, R. S., Frederick, C., Nader, K., Arroyo, W., Steinberg, A., Eth, S., Nunez, F. & Fairbanks, L. (1987). Life threat and post traumatic stress in school-age children. *Archives of General Psychiatry, 44*, 1057-1063.

Rucklidge, J.D. (2006). *Journal of Affective Disorders, 91*, 181-188.

Seedat, S., Nyamai, C., Njenga, F., Vythilingum, B., & Stein, D. J. (2004). Trauma exposure and post-traumatic stress symptoms in urban African schools. *British Journal of Psychiatry, 184*, 169-175.

Stallard, P., & Salter, E. (2003). Psychological debriefing with children and young people following traumatic events. *Clinical Child Psychology and Psychiatry, 8*, 445-457.

Traweek, S.L. (2006). Attention deficit-hyperactivity disorder and posttraumatic stress disorder: misdiagnosis of high risk school-ages girls exposed to violence and trauma. *Dissertation Abstracts International: Section B: The Sciences and Engineering, 66* (10-B), 5696.

94

Selected References

Van Emmerik, A. P., Kamphuis, J. H., Hulsbosch, & Emmelkamp, P. M. (2002). Single session debriefing after psychological trauma: A meta-analysis. *The Lancet, 360*, 766- 770.

Yorbik, O., Akbiyik, D. I., Kirmizigul, P., & Söhmen, T. (2004). Post-traumatic Stress Disorder symptoms in children after the 1999 Marmara earthquake in Turkey. *International Journal of Mental Health, 33*, 46-58.

95

PTSD at School

Stephen E. Brock, Ph.D., NCSP
California State University, Sacramento
brock@csus.edu



Idaho School Counselor Association (ISCA) & Idaho School Psychologist Association (ISPA) Critical Skills and Issues in School Psychology Fall Conference, October 2, 2008, Boise, ID

96
